STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25E115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE RETIREMENT HOME	**209 OAK CIRCLE , DUNCAN, Mississippi, 38740**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey with one (1) complaint, MS CI # 2638073 at the facility from 11/11/25-11/13/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F606, F641, F656, F677, and F688. There were no deficiencies cited for CI MS# 2638073 related to environment, resident rights, and quality of care. The census at the time of the survey was 56 and the facility is licensed for 60 beds.	F0000		
F0606 SS = D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.	F0606		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0606 SS = D	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to ensure that pre-employment background checks were completed prior to allowing newly hired direct care staff to work for two (2) of five (5) employee files reviewed, Certified Nurse Assistant (CNA) #3 and Licensed Practical Nurse (LPN) #4 Findings include: Review of the facility policy titled, “Abuse, Neglect, and Exploitation,” last reviewed 1/2024, revealed: “The facility has developed policies and procedures which provide essential components to an abuse prevention and intervention program. The program encompasses the following components: 1.) Screening of potential hires: criminal background checks.” Review of the Employee Handbook dated March 2021 revealed under Background Check: “All new hires of the facility are required to undergo a criminal background check.” Review of CNA #3’s personnel record and time sheets revealed she was hired on 10/6/25 with no background check and had been allowed to work 21 days between 10/7/25-11/12/25. Review of LPN #4’s personnel record and time sheets revealed she was hired on 10/12/25 with no background check and was allowed to work 12 days between 10/13/25-11/12/25. During an interview with LPN #4, she confirmed she was hired at the facility on 10/12/25 and that she had not completed a background check. She stated she missed her first appointment and had never rescheduled it. During an interview with the Administrator (ADM) on 11/13/25 at 11:00 AM, she confirmed the staff did not have background checks in their files and that it was the Business Office Manager’s (BOM) responsibility to ensure all staff had completed background checks. She stated the purpose of background checks is to identify any concerns that may prevent hiring of the individual and that background checks are a component of abuse prevention. During an interview with the BOM on 11/13/25 at 11:30 AM, she confirmed she was responsible for ensuring all new hires had background checks. She stated both staff members told her on the date of hire that they had	F0606		

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F0606 SS = D	Continued from page 2 completed previous background checks and would bring documentation in. She stated she never received the background checks and failed to follow up. She further stated she should not have allowed the staff to work until the facility had the background check, but that staffing shortages influenced the decision to let them work.	F0606		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview and record review, the facility failed to accurately complete a Minimum Data	F0641		

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F0641 SS = D	Continued from page 3 Set (MDS)Assessment related to coding a resident as having a serious mental illness for one (1) of 17 resident MDS assessments reviewed. Resident #3. Findings Include: Review of the Facility Policy titled, "Coordination/Certification of Assessments" with reviewed date of 01/2024 revealed, "Each resident's assessment will be coordinated by and certified as complete by a Registered Nurse, and all individuals who complete a portion of the assessment will sign and certify the accuracy of the portion of the assessment he or she completed...." Record review of Resident #3's "Admission Record" revealed an initial admission date of 01/11/2019 with medical diagnoses that included Unspecified Mood (Affective) Disorder and Psychotic Disorder with Delusions Due To Known Physiological Condition. Record review of Resident #3's Annual MDS assessment with an Assessment Reference Date (ARD) of 02/20/25 revealed under Section A1500t that he was not currently considered by the state level II PASRR (Preadmission Screening and Resident Review) process to have serious mental illness and/or intellectual disability or a related condition and under Section I that he had a diagnosis of Psychotic Disorder (other than schizophrenia). An interview on 11/13/25 at 9:40 AM with MDS) Nurse revealed that the Annual MDS with ARD of 02/20/25 under Section A under 1500 was answered incorrectly. She revealed that the question "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition" was answered "No." MDS Nurse confirmed that Resident #3 had a diagnosis of Psychotic Disorder with Delusions due to known Physiological Condition. She also revealed that inaccurately coding the MDS Assessment could prevent Resident #3 from receiving services he may need. Bottom of Form	F0641		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F0656		

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F0656 SS = D	Continued from page 4 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by:	F0656		

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F0656 SS = D	Continued from page 5 Based on observations, staff interviews, and record review the facility failed to develop a care plan related to contractures for Resident #25 and failed to implement a care plan related to nail care for Resident #29 for (2) two of 23 sampled resident care plans reviewed. Resident #25 and 29 Findings include: Review of typed statement on facility letterhead revealed "Proper Name" retirement home follows the RAI (Resident Assessment Instrument) manual as a policy for initiating, completing, and updating of the care plan. ... Resident #25 An observation of Resident #25 on 11/11/25 at 12:00 PM and again on 11/12/25 at 9:00AM and 1:00PM revealed a right-hand contracture with no device in place for positioning or protection. An interview with the Minimum Data Set (MDS) Nurse on 11/13/25 at 9:30 AM confirmed there was no care plan developed addressing Resident #25's right-hand contracture or ROM needs. She stated the care plan should identify resident-specific needs and guide staff on the interventions required, and that failing to develop a care plan for a resident's need could result in the residents not receiving the care they require. Record review of the "Admission Record" for Resident #25 revealed the facility admitted the resident on 3/4/25 with diagnoses including right-sided hemiplegia and contractures. Record review of Resident #25's MDS assessment with an Assessment Reference Date (ARD) of 9/17/25 revealed in Section GG0115 that the resident had an Impairment on both sides of upper extremities. Resident #29 An observation on 11/11/25 at 1:00 PM and again on 11/12/25 at 1:50 PM, revealed Resident #29 with long, dirty fingernails on both of his hands. His fingernails were approximately one-fourth to one-half of an inch long with a brown substance underneath. During an observation and interview on 11/12/25 at 1:55 PM with Certified Nursing Assistant (CNA) #1, she confirmed that Resident #29's fingernails were long and dirty with a brown substance underneath. She admitted	F0656		

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F0656 SS = D	Continued from page 6 that his fingernails should have been taken care of yesterday during his shower time. An interview on 11/13/25 at 9:45 AM with the MDS Nurse confirmed that Resident #29/s care plan was not followed, because his fingernail care had not been completed. Record review of Resident #29's "Care Plan Report" revealed that he had a "Self-Care Deficit" and required assistance with Activities of Daily Living (ADL) including bathing, dressing, and personal hygiene. Record review of Resident #29's "Admission Record" revealed the facility admitted the resident on 02/25/25 with medical diagnoses that included Peripheral Vascular Disease and Acquired Absence of Left Leg Below Knee.	F0656		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to provide ADL (Activities of Daily Living) care related to fingernail hygiene for 1 (one) of 56 residents residing in the facility. Resident #29. Findings Include: Review of the typed statement on facility letterhead by the Administrator (ADM)revealed, "Proper Name" (facility) follows the RAI (Resident Assessment Instrument) manual for the Activities of Daily Living policy." Observations on 11/11/25 at 1:00 PM and on 11/12/25 at 1:50 PM revealed Resident #29 with long, dirty fingernails. His fingernails on both hands were approximately one-fourth to one-half an inch long and they had brown substance underneath. During an observation and interview on 11/12/25 at 1:55	F0677		

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F0677 SS = D	Continued from page 7 PM with Certified Nursing Assistant (CNA) #1, she confirmed that Resident #29 had long fingernails with a brown substance underneath. She stated that unkept fingernails could cause the spread of germs and infection if he scratched himself. CNA #1 revealed that Resident #29's scheduled shower days were Tuesdays, Thursdays, and Saturdays and that his nails should have been taken care of yesterday An interview on 11/12/25 at 2:05 PM with Licensed Practical Nurse (LPN) #1 confirmed that his fingernails were long and dirty and that the CNAs were responsible for taking care of fingernails during shower or bath time but admitted that she was assigned to him today. She also confirmed that he had his shower yesterday and his fingernails should have been cleaned and clipped then. Record review of Resident #29's "Care Plan Report" revealed that he had a "Self-Care Deficit" and required assistance with all ADLs including bathing, dressing, and personal hygiene. Record review of Resident #29's "Admission Record" revealed the facility admitted the resident on 02/25/25 with medical diagnosis that included Peripheral Vascular Disease and Acquired Absence of Left Leg Below Knee. Record review of Resident #29's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/10/25 revealed a Brief Interview for Mental Status (BIMS) Score of 06 which indicated that he had severe cognitive deficit.	F0677		
F0688 SS = E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F0688		

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F0688 SS = E	Continued from page 8 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure proper positioning for (Resident #14) and failed to provide range of motion (ROM) services for Resident #25 to prevent further decline in physical functioning. This deficient practice was identified for two (2) of three (3) residents reviewed for ROM and positioning. Findings include: Review of the facility policy titled, “Mobility and Range of Motion,” last reviewed January 2024, revealed: “Policy Statement: Residents with limited range of motion (ROM) will receive treatment and services to increase and/or prevent further decrease in ROM. … Residents with limited mobility will receive appropriate services, equipment, and assistance to maintain or improve mobility.” Resident #14 An observation on 11/11/2025 at 12:55 PM and again on 11/12/2025 at 9:25 AM, and 11:05 AM revealed Resident #14 sitting in a wheelchair, leaning to the right with her right arm resting on the top of the wheel. The wheelchair did not have a right-side armrest in place to support her positioning. An observation on 11/12/2025 at 12:20 PM revealed Resident #14 sitting in her wheelchair at the dining table being assisted with her meal by a staff member while continuing to lean to the right with no arm rest. During an interview on 11/12/2025 at 1:00 PM, the Therapy Director revealed that Resident #14 leans to the right and requires an armrest to assist with positioning. She stated she was not aware that the right-side armrest was not in place. During an interview and observation on 11/12/2025 at 1:10 PM, the Physical Therapy Assistant (PTA) confirmed that Resident #14’s right wheelchair arm rest was not attached. The PTA admitted that the resident had been	F0688		

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F0688 SS = E	Continued from page 9 on their PT case load in June and that the resident needed the armrest in place to help her with positioning and trunk control. During an interview and observation on 11/12/2025 at 1:20 PM, Certified Nurse Aide (CNA) #2 confirmed that Resident #14's armrest should be attached to her wheelchair because she leans all of the time and it helps with the resident's positioning She reported that staff reposition her when they notice her leaning, but she had not realized the right-side armrest was missing until it was brought to her attention by the State Agent (SA). During an interview on 11/12/2025 at 1:34 PM, Licensed Practical Nurse (LPN) #3 confirmed that Resident #14's right wheelchair armrest was missing and should be in place to help with her positioning. She also confirmed that the resident frequently leans to the right, and staff reposition her as needed. During an interview on 11/12/2025 at 2:21 PM, the Administrator (ADM) admitted that Resident #14 leans to the side in her wheelchair and that the resident had previously participated in therapy but was unaware that the wheelchair was missing the right-side armrest. She confirmed the armrest, or some positioning device would assist with reducing her leaning, but that was unaware they were not being used. During an interview on 11/13/2025 at 9:20 AM, the Physical Therapist confirmed that the right-side armrest is essential for supporting Resident #14's positioning and should always be attached to the wheelchair. Review of Resident #14's "Admission Record" revealed the facility admitted the resident on 1/23/25 with diagnoses including Lack of coordination and Abnormal Posture. Resident #25 On 11/11/25 at 12:00 PM and again on 11/12/25 at 9:00 AM and 1:00 PM Resident #25 was observed with a right-hand contracture that had no device in place for positioning or protection. During an interview on 11/12/25 at 11:00 AM, Certified Nurse Assistant (CNA) #1 confirmed she was assigned to Resident #25 and was unaware of any interventions for the right-hand contracture. She stated no tasks were	F0688		

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F0688 SS = E	Continued from page 10 listed for her to chart related to ROM or positioning for the resident's hand. During an observation with Licensed Practical Nurse (LPN) #1 on 11/13/25 at 8:00 AM, she confirmed the Resident #25's fingers on the resident's right hand were tightly contracted into the palm and no device or positioning intervention was in place. She stated that the resident "could use some type of therapy or ROM so it doesn't get worse." No skin breakdown was observed. An interview with CNA #2 on 11/13/25 at 8:28 AM revealed she was also unaware of any ROM or positioning services being provided for Resident #25's right hand contracture. During an interview with the ADM on 11/13/25 at 9:10 AM, she confirmed she could not find any documentation indicating ROM or positioning services for the Resident #25's right-hand contracture. She confirmed the resident should be receiving ROM and stated failure to provide ROM could cause the contracture to worsen. An interview with the Occupational Therapist on 11/13/25 at 9:40 AM confirmed that Resident #25 had a right-hand contracture and staff "should be doing ROM with care to prevent worsening." He stated the resident was discharged from OT services on 10/17/25 and no follow-up interventions were ordered, but maintenance ROM and positioning should have continued with nursing staff. Record review of Resident #25's "Admission Record" revealed the facility admitted the resident onn3/4/25 with diagnoses including right-sided hemiplegia and contractures. Record review of Resident #25s MDS with and ARD of 9/17/25 revealed the resident had an Impairment on both sides of upper extremities.	F0688		